

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2012	
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/13/12</p> <p>Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Castleton Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has a capacity of 109 and had a census of 64 at the time of</p>		K0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/14/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0048 SS=E	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Disaster Plan: Fire Emergency Procedure" during record review with the Maintenance Director and the Housekeeping/Laundry Supervisor from 9:40 a.m. to 11:20 a.m. on 02/13/12, the fire safety plan did not address the use of the K class fire extinguisher located in</p>		K0048	<p>Element #1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy to have a written plan for the protection of all patients and for their evacuation in the event of an emergency. The facility "DisasterPlan: Fire Emergency Procedure" has been reviewed and updated to address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The kitchen staff have been trained to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher. Element #2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this practice. All kitchen staff have been in-serviced/trained to activate the kitchen overhead extinguishing system to suppress a fire prior to using the K class fire extinguisher. Going forward all future kitchen staff will be trained upon hire on how to activate the kitchen overhead extinguishing system to suppress a fire prior to</p>		02/29/2012	

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	<p>the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</p> <p>3.1-19(b)</p>			<p>using the K class fire extinguisher. The maintenance director or designee will monitor and question all kitchen staff monthly to ensure proper procedures are being followed per the facility's updated "Disaster Plan: Fire Emergency Procedure". Element #3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; At an in-service held February 28, 2012 all kitchen staff and maintenance staff were educated on how and when to activate the kitchen overhead extinguishing system to suppress a fire before using the K class fire extinguisher. Any staff who fail when asked to demonstrate the proper procedure as per the updated Fire Emergency Plan will be progressive disciplined up to and including termination. Element #4 How will the facility's corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put in place; and by what date the systemic changes will be completed. At the monthly Quality Assurance meeting all monitoring results will be discussed. Any negative patterns will be addressed. If necessary the administrator will write an action plan and monitor weekly until compliance is met.</p>			

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K0050 SS=C	<p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Director and the Housekeeping/Laundry Supervisor during record review from 9:40 a.m. to 11:20 a.m. on 02/13/12, first shift fire drills conducted on 04/29/11, 08/18/11 and 10/31/11 were conducted at, respectively, 8:55 a.m., 9:22 a.m. and 9:52 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged first shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>	K0050	<p>Element #1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of this facility to hold fire drills at unexpected times and under varying conditions, one on each shift at least quarterly. Though the facility did hold fire drills (one on each shift quarterly) they did fail to do at various times on the 6am to 2pm shift. The Administrator and Maintenance Director have implemented monthly meetings to coordinate times and days per shift per quarter for fire drills to be performed. Element #2 How have other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents/staff/vendors and visitors have the potential to be affected by this practice. The facility will monitor all times and shifts of future fire drills. The Maintenance Director or designee will ensure that fire drills are given</p>		02/29/2012		

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				<p>at various times throughout all shifts to be unexpected times under varying conditions. The Maintenance Director or designee will keep recorded monitorings to ensure this is completed in accordance to safety regulations. Element #3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; At an in-service held February 28th 2012 all staff were informed of fire drill to be held at unexpected times under varying conditions. The Maintenance Director was educated by the Administrator also on all monitorings and implementation for future fire drills. Element #4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place; and by what date the systemic changes will be completed. At the monthly Quality Assurance meetings the Maintenance Director or designee will bring all dates and times of fire drills held for the previous month and past quarter. All monitorings of the past (4) consecutive quarters will be reviewed. Any negative patterns of the for mention procedure will be discuss. If necessary an action plan will be written and monitored weekly by the Administrator until compliance is met.</p>			

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K0052 SS=F	<p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>		K0052	<p>Element #1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of this facility to ensure the safety of all residents, staff, and visitors. The Fire Alarm Circuit Control switch is now protected by a locked door leading to the circuit control switch breaker room. Only authorized personnel have access to the room containing the Fire Alarm Circuit Control Switch Breaker. It is also the policy of this facility to ensure all smoke detectors are in accordance with Life Safety Code Standards. Ceiling fans located in the corridor next to resident rooms 106, 225 and 230 and in the corridor next to the MDS/Restorative Office have had their blades removed as to not interfere with in a direct airflow from an air supply diffuser or return air opening. Element #2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents, staff, and visitors have the potential to be affected by the unlocked door. The door is now</p>		02/29/2012	

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping/Laundry Supervisor during a tour of the facility from 11:20 a.m. to 12:55 p.m. on 02/13/12, access to the fire alarm system breaker located in the transfer switch room was not locked. Neither the breaker panel in which the fire alarm system breaker was located was locked nor was the door to the transfer switch room locked. Based on interview at the time of observation, the Maintenance Director and the Housekeeping/Laundry Supervisor acknowledged access to the fire alarm system breaker located in the transfer switch room was not locked.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 4 of 36 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could</p>		<p>locked and only authorized personnel have access to the room containing the Fire Alarm Circuit Control Switch Breaker. The Maintenance Director or designee will monitor monthly to ensure the door remains locked and only authorized personnel have access. The Maintenance Director or designee will also monitor monthly all smoke detectors in the corridors to ensure no interference is occurring. Element #3 what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; At an in-service held February 28, 2012 the locked door and access to the Fire Alarm Circuit Control Switch Breaker was discussed. Also smoke detectors having a 3 foot clearance was discussed. Element #4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systematic changes will be completed. At the monthly Quality Assurance Meeting all monitorings of the locked door leading to the Alarm Circuit Control Switch Breaker and smoke detector clearance will be discussed. Any negative patterns will be addressed. If necessary an action plan will be written by the Administrator and monitored weekly.</p>				

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	<p>affect residents, staff or visitors in the vicinity of resident room 106, 225 and 230 and in the vicinity of the MDS/Restorative office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping/Laundry Supervisor during a tour of the facility from 11:20 a.m. to 12:55 p.m. on 02/13/12, smoke detectors in the corridor next to resident room 106, 225 and 230 and in the corridor next to the MDS/Restorative office were each located on the ceiling within one foot of a ceiling fan. Based on interview at the time of the observations, the Maintenance Director and the Housekeeping/Laundry Supervisor each acknowledged the four smoke detectors were installed within one foot of a ceiling fan.</p> <p>3.1-19(b)</p>						